Department of Veterans Affairs
Office of Inspector General
December 2013 Highlights

CONGRESSIONAL TESTIMONY

OIG Tells Congress VA Continues to Face Challenges in Improving Accuracy and Timeliness of Disability Claims

Ms. Sondra McCauley, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on the results of Office of Inspector General (OIG) inspections of VA Regional Offices (VAROs). OIG conducts cyclical reviews which include how well the VAROs process high-risk claims. OIG continues to find error rates of about 30 percent in the VARO processing of claims for traumatic brain injury (TBI) and temporary 100 percent disability ratings.
Ms. McCauley also discussed OIG's ongoing work reviewing the Veterans Benefits Administration's initiative dealing with claims over 2 years old and the accuracy of claims processed in the Veterans Benefits Management System. Ms. McCauley was accompanied by Mr. Brent Arronte, Director, San Diego Benefits Inspections Division. [Click here to access testimony.]

OIG REPORTS

Stronger Accountability over Cost, Schedule, and Scope for Development of VA's Pharmacy Reengineering Project Needed

OIG evaluated the effectiveness of the Office of Information and Technology's (OIT) management of the Pharmacy Reengineering (PRE) project, which was restarted in October 2009 under the Project Management Accountability System (PMAS). Although some progress has been made, OIT has not been effective in keeping the PRE project on target in terms of schedule, cost, and the functionality delivered. Specifically, deployed PRE functionality has improved patient safety; however, project managers have struggled to deploy PRE increments in a timely manner. Project managers were also unable to provide reliable costs at the increment level. OIT restarted PRE at a time when PMAS had not evolved to provide the oversight needed to ensure project success. As such, PRE management was challenged in keeping PRE on track and the project is at an increased risk of not being completed on time and within budget. Moreover, the future of Pharmacy Reengineering is uncertain due to potential plans to transfer funding and remaining development to the Integrated Electronic Health Record (iEHR) project in FY 2014. Stronger accountability over cost, schedule, and scope for the remaining development is needed prior to such a transfer so that iEHR is not compromised by the same challenges. OIG recommended the Executive in Charge and Chief Information Officer (CIO) ensure all of the time used to complete each remaining PRE increment is reported and monitored, including the time on the initial operating capability phase; ensure adequate oversight and controls, including the planning guidance, staffing, and cost and schedule tracking needed to deliver functionality on time and within budget; and establish a plan for future funding of PRE until iEHR is decided. The CIO agreed with OIG's recommendations and provided an acceptable corrective action plan. [Click here to access report.]

OIG Finds Quality of Care Issues, Poor Discharge Planning, and Lapses in Communication at San Juan VA Medical Center

OIG conducted an inspection to review allegations from a confidential complainant about quality of care issues, inadequate discharge planning, and lapses in communication at the San Juan VA Medical Center (VAMC), San Juan, Puerto Rico. OIG substantiated the allegations that the medical condition leading to the patient's acute delirium was not addressed, and that the patient was not medically stable when he left the facility. OIG substantiated the allegation that the patient lost a significant amount of weight while he was in the hospital, and determined that the patient's nutritional treatment plan was inadequate. OIG substantiated the allegation that the patient fell once, that family members did not receive adequate information regarding the patient's condition, and that no attempts were made by staff to arrange for appropriate follow-up care with providers at the Arizona VA facility. OIG determined that accurate skin assessments were not performed, and that actions taken to prevent and/or treat pressure ulcers were inadequate. OIG recommended that thorough nutritional assessments are completed (including weights), processes be strengthened to ensure nursing staff perform accurate daily skin inspections, and that discharge planning processes are appropriate for the patient's condition. OIG also recommended that the informed consent process complies with Veterans Health Administration (VHA) requirements, and that the Facility Director consult with Regional Counsel regarding possible disclosure of failure to diagnose a urinary tract infection and prevent and treat pressure ulcers. [Click here to access report.]

Improvements Needed in Length of Stay and Patient Flow Practices at Emergency Department of Jesse Brown VAMC, Chicago, Illinois

OIG conducted an inspection in response to a complainant's allegations of a delay in chemotherapy treatment, excessive length of stay (LOS) in the Emergency Department (ED), and failure to perform a kidney ultrasound at the Jesse Brown VAMC in Chicago, IL. OIG substantiated a delay in chemotherapy treatment, that the patient experienced excessive LOS in the ED on two occasions while awaiting admission, and that an inpatient kidney ultrasound was ordered but not performed. However, on both ED visits, the patient was promptly triaged and treated. OIG could not substantiate that the patient suffered adverse medical outcomes as a result of these delays. OIG found that there was no clearly defined process for monitoring oncology clinic patients awaiting inpatient beds after hours and that there was inconsistent patient handoff communication between oncology clinic staff and the ED triage nurses. OIG also identified problems in the Patient Flow Committee structure, membership, and communication of patient flow initiatives to the frontline staff. OIG made three recommendations. [Click here to access report.]

Inadequate Staffing Results in Lengthy Call Center Wait Times at VA Eastern Colorado Health Care System, Denver, Colorado

OIG conducted an inspection to assess the validity of allegations regarding the ED and the Health Information Call Center (Call Center) at the VA Eastern Colorado Health Care System, Denver, CO. OIG did not substantiate the allegation that the ED "needs help." While OIG found some ED wait times exceeded 8 hours, OIG determined the

facility met VHA's target of less than 10 percent of patients with a LOS over 6 hours. OIG did not substantiate the allegation that ED staff treated two patients discourteously, or that one of the patients was afraid to return to the ED due to alleged discourteous treatment. OIG substantiated the allegations that Call Center understaffing caused long call waiting times and callers to abandon calls. OIG found 40 percent of the Call Center's authorized registered nurse, medical support assistant, and pharmacy technician positions were vacant and determined that inadequate staffing contributed to the Call Center's failure to meet VHA targets for caller response time and call abandonment rates. OIG also found that calls were dropped due to the telephone system's 120-line limitation, and callers who used the automated call return system did not always receive a return call. An upgrade of the telephone system is not planned until fiscal year (FY) 2016 when the facility relocates. Additional staff and an upgraded system should eliminate the 120-line limitation and reduce callback system failures. OIG recommended that the Veterans Integrated Service Network and Facility Directors ensure processes are strengthened to improve Call Center practices and staffing levels. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Former VA Contract Health Care Worker Sentenced for Tampering

A former health care worker, who provided contract services to VA in 2008, was sentenced to 39 years' incarceration. The defendant previously pled guilty to acquiring or obtaining possession of a controlled substance by fraud and tampering with consumer products with reckless disregard. A multi-agency investigation disclosed that the defendant stole syringes of fentanyl prepared for patients scheduled to undergo a medical procedure. The defendant then used the stolen syringes to inject himself, causing the syringes to become tainted with his Hepatitis C infected blood, before filling them with saline and then replacing them for use in the medical procedure. As a result, more than 12,000 patients were recommended to be tested for Hepatitis C. Testing identified 45 patients who were infected with the disease, to include 3 Veterans. Two of the Veterans were exposed to the defendant's blood during procedures at a private hospital and one during a procedure at a VAMC.

Alexandria, Louisiana, VAMC Nursing Assistant Arrested for Manslaughter

A nursing assistant at the Alexandria, LA, VAMC was arrested on a manslaughter charge related to an altercation with an elderly patient in the medical center's mental health unit.

Veteran Pleads Guilty to Wire Fraud

A Veteran pled guilty to wire fraud after a VA OIG and Small Business Administration OIG investigation revealed that he fraudulently claimed to be the owner of a Service-Disabled Veteran-Owned Small Business in order to qualify for and obtain $1.4 million in VA contracts for architectural and engineering services. The Veteran did not have a service-connected disability and had previously been denied VA benefits.

Veteran Pleads Guilty To Threatening to Murder a Government Employee
A Veteran pled guilty to threatening to murder a Government employee. An OIG and VA Police Service investigation revealed that in August 2013 the defendant made several threats to kill Seattle, WA, VAMC employees and police officers. The defendant remains in custody pending trial.

Major Teaching Hospital Reimburses VA for Overbilling
A major teaching hospital, which provided VA fee basis radiation proton therapy treatments, reimbursed VA $557,661 as the result of an agreement negotiated with the assistance of the U.S. Attorney's Office, Civil Division. An OIG investigation revealed that the hospital overbilled VA for radiation treatments.

Veteran Charged with Making Threats to the Pembroke Pines, Florida, VA Community Based Outpatient Clinic
A Veteran was charged with making harassing telephone calls. An OIG investigation revealed that the defendant made numerous threatening calls to the Pembroke Pines, FL, VA Community Based Outpatient Clinic (CBOC) threatening the staff. The Veteran repeatedly called the clinic and threatened to commit mass murder if he did not receive additional narcotics. The threats resulted in the clinic's closure and patients' appointment cancellations.

Veteran Arrested for the Assault of Waco, Texas, VAMC Psychiatrist
A Veteran was arrested for assaulting a VA psychiatrist at the Waco, TX, VAMC. The defendant choked the psychiatrist while being admitted as a psychiatric inpatient.

VA Police Officer Pleads Guilty to Interstate Communications
A VA Police Officer pled guilty to interstate communications (extortion). An OIG investigation revealed that the officer used his position to access a State law enforcement database to obtain personal information regarding a U.S. Army service member and extorted the service member by threatening to post sexually explicit images and provide embarrassing information on social media if the victim failed to pay additional money on a previously satisfied personal loan. The defendant used VA networks and computers to send the extortion e-mails to the victim. Also, while off-duty and not in any official capacity, the defendant conducted a traffic stop of an off-duty local police officer using his personally owned vehicle, equipped with emergency lights, siren, and radio.

Hines, Illinois, VA Employee Charged With Theft
A VA Hines Information Technology Center (Center) employee was charged with theft. During an OIG investigation, the defendant admitted that he stole 17 newly purchased laptop computers from the Center. Some of the computers were then pawned at a local shop by the defendant's wife.

Former Miami, Florida, VAMC Canteen Service Chief Sentenced for Theft
A former chief of the Veterans Canteen Service at the Miami, FL, VAMC was sentenced to 3 years' probation, 50 hours' community service, and ordered to attend drug

treatment and to pay $6,716 in restitution after pleading guilty to organized fraud and grand theft. An OIG investigation revealed that the defendant stole VA property, cash, a laptop computer, a Blackberry; misused his Government issued travel card; and negotiated several bad checks. The loss is $22,450.

Former Rochester, New York, CBOC Employee Pleads Guilty to Workers' Compensation Fraud

A former VA medical technician at a CBOC in Rochester, NY, pled guilty to a criminal information charging workers' compensation fraud. A VA OIG and Department of Labor (DOL) OIG investigation revealed that the defendant claimed to have suffered a back injury while employed by VA and was medically limited to the number of hours she could work. The defendant began receiving workers' compensation in August 2010 and during the same time period applied for a State license to open a liquor store in which she was listed as president, manager, and sole proprietor. The defendant was observed on multiple occasions working in the liquor store, climbing staircases, reaching for and replacing bottles, carrying large heavy bags, and assisting customers. The defendant continued filing forms with DOL certifying that she was not engaged in any outside employment.

Former Ft. Harrison, Montana, VAMC Contract Employee Sentenced for Drug Diversion

A former Ft. Harrison, MT, VAMC contract employee was sentenced to 5 years' supervised release and barred from employment as a nurse anesthetist. An OIG investigation revealed that the defendant engaged in the diversion and use of sufentanil, hydromorphone, and other injectable narcotics from the medical center. The defendant was falsely claiming to administer narcotics to patients under anesthesia, when in fact the narcotics were diverted for his personal use.

Non-Veteran Sentenced for Health Care Fraud

A non-Veteran was sentenced to 41 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $306,660. An OIG investigation determined that the defendant forged a DD-214, claiming to be an eligible Veteran. Based on the forged DD-214, the defendant received VA health care, including medication, from April 2009 to August 2012 from various VAMCs.

Non-Veterans Indicted for Health Care Fraud

A non-Veteran was indicted for theft of Government funds after fraudulently receiving VA health care and other benefits at the Asheville, NC, and Salisbury, NC, VAMCs. The defendant claimed to have served several years in the U. S. Marine Corps, including time in Vietnam. An OIG investigation determined that during much of the time the defendant claimed to have been in military service he was incarcerated. The defendant was the subject of a previous OIG investigation in which he was convicted of the same offense and was sentenced to 2 years' incarceration. The loss to VA is approximately $31,500. In an unrelated case, a second non-Veteran, who falsely claimed to be a Veteran, was indicted for health care fraud. An OIG investigation determined that between April 2003 and April 2012 the defendant fraudulently received

VA health care, travel benefits, and Department of Housing and Urban Development–Veterans Affairs Supportive Housing from the Roseburg, OR, VAMC. The loss to VA is approximately $32,000.

Veteran Enters Pre-Trial Diversion Program After Altering DD-214
A Veteran entered into a Veterans' Court pre-trial diversion program for 12 months. An OIG investigation revealed that the defendant altered his DD-214 to reflect combat service in Vietnam, to include receiving a Combat Infantryman's Badge, Vietnam Campaign Medal, Vietnam Service Medal, and Purple Heart Medal. The defendant wanted to qualify for additional compensation for post-traumatic stress disorder (PTSD) and health care benefits. The defendant admitted to altering the DD-214 and only serving in Germany.

Non-Veteran Pleads Guilty to Fraud
A non-Veteran pled guilty to conspiracy to commit mail, wire, and bank fraud. An OIG and Federal Bureau of Investigation investigation determined that the defendant provided down payments to multiple buyers during real estate closings that were reported to the lenders as originating from a family member of the buyer. The funds were fraudulently reported on the Uniform Residential Loan Application to increase the buyer's credit scores, allowing them to qualify for mortgages they were not otherwise qualified to receive. Thirteen loans were identified in the scheme, to include a VA-guaranteed home loan. The potential loss to VA should this guaranteed VA home loan default is approximately $152,203.

Defendant Pleads Guilty in Deceased Beneficiary Investigation
A subject pled guilty to misuse of a Social Security number after a VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant assisted the daughter of a deceased beneficiary with forging and negotiating VA and SSA benefit checks that were issued after the beneficiary's death in July 2002. The defendant used false identifiers to open bank accounts through which the checks were negotiated. The daughter of the deceased beneficiary was previously sentenced in this case. The loss to VA is approximately $120,500.

Niece of Deceased VA Beneficiary Indicted for Theft
The niece of a deceased VA dependency and indemnity compensation beneficiary was indicted for theft of public money. During an OIG investigation, the defendant admitted to stealing VA funds that were direct deposited after her aunt's death in April 2005. The defendant stated that she used the VA funds to pay her aunt's medical bills and her own expenses. The loss to VA is $105,765.

Veterans Sentenced for VA Pension Beneficiary Fraud
A Veteran was sentenced to 6 months' incarceration, 8 months' home detention, 3 years' probation, and ordered to pay restitution of $75,246 after pleading guilty to theft of Government funds and making false statements. An OIG investigation revealed that the Veteran fraudulently obtained a VA pension by falsifying his initial application and attempting to hide his assets from VA. A second Veteran was sentenced to 9 months'

home confinement, 3 years' probation, and ordered to pay restitution of $61,129 after pleading guilty to theft of Government funds and identity theft. An OIG investigation revealed that the defendant fraudulently reported no income and his inability to work in order to receive VA pension benefits. The defendant also opened numerous bank accounts, using fraudulent identities, in order to hide almost $1 million in unreported funds while receiving the VA pension benefits.

Veteran Pleads Guilty to Travel Benefit Fraud
A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he submitted 148 fraudulent travel vouchers to the Salt Lake City, UT, VAMC. The defendant fraudulently claimed that he attended VA-sponsored physical therapy appointments at an affiliate university and provided forged letters from the university to support his claim. The loss to VA is $10,687.

Veteran Indicted for False Claims and Wire Fraud
A Veteran was indicted for false claims and wire fraud after an OIG investigation revealed that he fraudulently claimed PTSD and TBI as a result of having been injured by an improvised explosive device during combat operations in Iraq. The defendant subsequently received compensation for PTSD due to the fraudulent claims. The investigation further revealed that the defendant was never injured during his service in Iraq. The loss to VA is approximately $45,290.

Veteran Sentenced for Fraud
A Veteran was sentenced to 63 months' incarceration, 36 months' supervised release, fined $5,000, and ordered to pay restitution of $263,937 after pleading guilty to mail fraud and making false material statements. An OIG and U.S. Postal Inspection Service investigation determined that from 2005 to 2011, the Veteran repeatedly certified he had not been employed during the preceding 12 months. During that time the Veteran received royalties and investment income from selling worthless stock to investors pertaining to a drug he marketed as a treatment for cancer and other illnesses.

Veteran Sentenced for False Statements
A Veteran was sentenced to 5 years' probation, to include 12 months' electronic monitoring, and ordered to pay restitution of $144,000 after pleading guilty to making false statements to VA. Since 2000, the Veteran reported to VA that he was not working and had no income. This false claim resulted in the defendant's receipt of VA pension benefits and aid and attendance. An OIG investigation determined that the defendant was serving as a Pastor and had the church pay his bi-weekly salary to his wife, who was also his VA-appointed fiduciary. During this time period, while presumed to be permanently and totally disabled, the defendant also performed miscellaneous maintenance work, towing, welding, and drove a race car, which earned him income above the allowable limits.

Former VA Fiduciary Sentenced for Harboring Foreign National
A former VA fiduciary was sentenced to 3 years' probation, a $3,000 fine, and 100 hours' community service after pleading guilty to harboring a foreign national. The

defendant, an attorney, is also required to disclose his felony conviction to the State Bars of Nevada and California. An OIG investigation revealed that the defendant became romantically involved with a female co-defendant and helped arrange a marriage between the co-defendant and an incompetent Veteran for whom he acted as fiduciary.

Non-Veteran Indicted for Fraudulent Claims
A non-Veteran was indicted for false, fictitious, or fraudulent claims after an OIG investigation revealed that the defendant, who never served in the U.S. military, fraudulently received $55,458 in VA medical treatment. The defendant also fraudulently filed seven claims for VA pension and disability compensation.

Veteran Sentenced for Theft of VA Benefits from Deceased Beneficiary
A Veteran was sentenced to 13 months' incarceration, 2 years' supervised release, and ordered to pay $124,944 in restitution after an OIG investigation revealed that the defendant received and negotiated VA benefit checks issued after the death of the beneficiary.

Defendant Sentenced for Theft of VA Benefit Check
A defendant was sentenced to 4 months' home detention and 1 year of probation after pleading guilty to theft of Government funds. An OIG and local police investigation revealed that the defendant sold a stolen $32,000 retroactive VA benefit check, issued to the daughter of a deceased Veteran, to an undercover officer.

Fugitive Veteran Arrested with Assistance of OIG and VA Police Service
A Veteran wanted in Arizona for a felony probation violation related to aggravated assault of a police officer was arrested in San Jose, CA, by the local police department with the assistance of OIG and the VA Police Service. The Veteran is pending extradition.

Richard J. Griffin
Acting Inspector General